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No. 91-1534

In the Supreme Court of the United States

OCTOBER TERM, 1991

TOTAL CARE, INC., PETITIONER

v.

LOUIS W. SULLIVAN, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

BRIEF FOR THE FEDERAL RESPONDENTS IN OPPOSITION

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QUESTIONS PRESENTED

1. Whether the district court was precluded by 42 U.S.C. 405(h) from exercising federal question jurisdiction over claims arising under Part A of the Medicare Act.

2. Whether petitioner was entitled to a writ of mandamus under 28 U.S.C. 1361.

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OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-6a) is unpublished, but the decision is noted at 952 F.2d 397 (Table). The opinion of the district court (Pet. App. 8a-19a) is reported at 754 F. Supp. 1097.

JURISDICTION

The judgment of the court of appeals was entered on December 23, 1991. The petition for a writ of certiorari was filed on March 21, 1992. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

1. The Medicare program, 42 U.S.C. 1395 *et seq.*, provides for payment of medical expenses for eligible aged and disabled persons. Part A of the Medicare program (Hospital Insurance Benefits) authorizes payments for primary institutional care to providers of services, including hospitals, skilled nursing facilities, and home health care organizations. See 42 U.S.C. 1395c-1395i. Part B of the Medicare program (Supplementary Medical Insurance Benefits) authorizes payments for physicians and other non-hospital services. See 42 U.S.C. 1395j-1395w. This case concerns a claim for reimbursement for home health care services under Part A.

a. Under Part A, the government reimburses providers for the services they furnish to beneficiaries. The provider receives either the "reasonable cost" or its "customary charge" for the services, whichever is less. 42 U.S.C. 1395f(b)(1).[1] A provider also receives a reasonable allowance for the services of its executives, including the owner of the enterprise, "providing their services are actually performed in a necessary function." 42 C.F.R. 413.5(c)(8). Reasonableness of executive compensation "may be determined by reference to, or in comparison with, compensation paid for comparable services and responsibilities in comparable institutions; or it may be determined by other appropriate means." 42 C.F.R. 413.102(c)(2).

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[1] Most Part A Medicare claims for hospital inpatient services are reimbursed in accordance with prospectively determined rates under the new Prospective Payment System (PPS). See 42 U.S.C. 1395ww(d). That system does not apply to claims for reimbursement for home health care services.

b. To handle the vast number of claims for payment under the Medicare program each year, Congress authorized the Secretary of Health and Human Services to contract with "fiscal intermediar[ies]," primarily insurance companies, to process providers' claims. 42 U.S.C. 1395h(a). At the end of each fiscal year, a provider submits to its fiscal intermediary a cost report for Medicare services rendered during the year. 42 C.F.R. 413.24(f). The fiscal intermediary reviews the cost report and furnishes the provider with a "Notice of Program Reimbursement" setting forth the total amount of reimbursement to which the intermediary believes the provider is entitled. 42 C.F.R. 405.1803. In making its determination, the intermediary must comply with the provisions of the Medicare Act, the Secretary's regulations, and rulings and instructions issued by the Health Care Financing Administration (HCFA) in the Department of Health and Human Services. 42 C.F.R. 405.1829(a).

If the provider disagrees with the intermediary's determination, and the amount in controversy is $10,000 or more, the provider may appeal to the Provider Reimbursement Review Board (Board). 42 U.S.C. 1395oo(a). The Board has authority to "affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination." 42 U.S.C. 1395oo(d). The Secretary has discretion to review the Board's decision within 60 days. 42 U.S.C. 1395oo(f). The Secretary has delegated his authority to review the Board's

decisions to the Administrator of HCFA. 42 C.F.R. 405.1875.

The provider may obtain judicial review of any final decision of the Board or the Administrator of HCFA by filing a civil action within 60 days. 42 U.S.C. 1395oo(f). The provider also may seek judicial review of "any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy" if the Board determines that it is without jurisdiction to decide the issue. Such an action must be filed within 60 days of the Board's notification that it is without jurisdiction. *Ibid.*

In addition, a provider may request an "expedited judicial review" (EJR) hearing to obtain a formal determination by the Board of its authority to decide questions of law relevant to the controversy. 42 U.S.C. 1395oo(f). A provider who requests an EJR hearing is responsible for submitting supporting documents and materials necessary for the Board to review the situation, after which the Board must determine within 30 days whether it has authority to decide the relevant questions. If the Board fails to decide within 30 days, the provider may seek judicial review. *Ibid.*

The administrative and judicial review provisions of the Medicare Act provide the exclusive means of obtaining review of decisions of the Board. The statute provides:

> The findings and decision of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No

> action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 1331 or 1346 of title 28 to recover on any claim arising under this subchapter.

42 U.S.C. 405(h) (incorporated into the Medicare Act by 42 U.S.C. 1395ii).

2. a. Petitioner Total Care, Inc., provides home health care services to patients in North Carolina and South Carolina. Respondents Blue Cross and Blue Shield Association and Blue Cross and Blue Shield of South Carolina (Blue Cross) act as fiscal intermediaries to providers such as petitioner.

Petitioner filed a cost report for the period ending December 31, 1987, with Blue Cross. Blue Cross initially approved all of petitioner's claimed executive compensation and reimbursed petitioner for those expenses. After the cost report was audited, however, Blue Cross issued a Notice of Program Reimbursement reducing the amount of executive compensation for 1987 by approximately $30,000. In arriving at this reduction, Blue Cross used the "Tennessee Point System." Under that system, the intermediary assigns points based on the executive's education, experience, and hours worked, and makes adjustments based on the number of home health care "visits" performed by the provider. Pet. App. 11a.

On October 16, 1989, petitioner requested an EJR hearing from the Board on the executive compensation issue. On February 21, 1990, at the Board's request, petitioner submitted additional documentation in support of its application for an expedited hearing. Pet. App. 11a.

b. Two months later—before the Board determined whether it had jurisdiction to consider petitioner's

EJR request—petitioner filed this action in district court against the Secretary, HCFA officials, and Blue Cross. Petitioner's complaint alleged that the Secretary's failure to issue proper guidance to fiscal intermediaries on the methods to be used to calculate reasonable compensation to home health care executives had caused petitioner to receive a reduced amount of Medicare reimbursement. In particular, petitioner alleged that the "Tennessee Point System" applied by Blue Cross is invalid as applied to home health care owners and that the system has been applied "selectively and therefore arbitrarily." Compl. ¶¶ 56-61. Petitioner alleged that Blue Cross had improperly reduced its reimbursement on the basis of this erroneous methodology on its cost report for fiscal year 1987, and on its Periodic Interim Payment (PIP) Reports for 1988 and 1989. *Id.* ¶ 65.

Petitioner sought an injunction preventing the defendants from reducing future Medicare reimbursements for executive compensation, and from retaining funds they have recouped, until "statistically valid guidelines for home health executive compensation" are issued. Compl. ¶ A. In addition, petitioner asked the court to "invoke its mandamus power" to direct the defendants to issue valid compensation guidelines and to "satisfy the Court that [respondents] properly applied those guidelines to [petitioner's] claimed executive compensation prior to being permitted to retain monies they have already recouped or withholding or reducing future monies." *Id.* ¶ C.

c. About three weeks after petitioner filed its complaint, the Board conducted a hearing on petitioner's EJR request and denied petitioner's request for expedited judicial review. The Board found that there were "[q]uestions of fact to be decided, and that the

central issue does not concern the validity of a law, regulation or HCFA ruling but whether a regulation was properly implemented." Pet. App. 11a.

3. The district court dismissed petitioner's action for lack of jurisdiction. The court rejected petitioner's claim that it had jurisdiction under 28 U.S.C. 1331, explaining that the Medicare Act, by incorporating 42 U.S.C. 405(h), expressly precludes an action under Section 1331 to recover on any Medicare claim. The court also found that petitioner's attempt to characterize this action as one "to enforce procedural regularities" was "suspect" in light of the allegations in the complaint. Pet. App. 13a-14a. In addition, the district court rejected petitioner's argument that it had jurisdiction to issue a writ of mandamus under 28 U.S.C. 1361. The court explained that, even if it had jurisdiction under the mandamus statute, it "would not issue a writ of mandamus in this case" because petitioner had failed to exhaust its administrative remedies. *Id.* at 15a-16a.[2]

4. The court of appeals affirmed the dismissal of petitioner's action in an unpublished opinion. Pet. App. 1a-6a. It agreed with the district court that 42 U.S.C. 405(h) precludes jurisdiction under 28 U.S.C. 1331. "By initiating this suit before the [Board] had heard or decided its EJR request," the court concluded, petitioner "failed to comply with the full procedures for administrative and judicial review under the Medicare Act." Pet. App. 5a. In addition, the court of appeals agreed with the district

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[2] The district court also rejected petitioner's arguments that it had jurisdiction under the All Writs Act, 28 U.S.C. 1651, and the expedited judicial review provision of the Medicare Act, 42 U.S.C. 1395oo. Pet. App. 16a-18a. Petitioner did not pursue those arguments in the court of appeals.

court "that [petitioner's] attempt to characterize this as an action to 'enforce procedural regularities' is suspect because [petitioner] continues to dispute its reimbursements for 1987, 1988, and 1989." *Ibid.* The court of appeals also rejected petitioner's claim of jurisdiction under 28 U.S.C. 1361. The court noted that mandamus jurisdiction is precluded under the Medicare Act where the plaintiff has failed to exhaust administrative remedies. Thus, the court of appeals concluded that "mandamus jurisdiction, even if available, would be inappropriate" in this case "in light of [petitioner's] failure to exhaust available avenues of relief." Pet. App. 6a.

5. While the case was pending in the court of appeals, the Board issued a decision granting petitioner's claim for executive compensation for 1987. The Board found that "the $86,322 compensation paid by the Provider to its owner/administrator is reasonable," and expressly rejected the methodology upon which Blue Cross relied. App., *infra*, 13a. The Board emphasized that the methodology for determining executive compensation must take into account salary amounts paid by comparable institutions, as well as market forces that determine salaries. *Id.* at 14a. The Administrator of HCFA declined to review the Board's decision. *Id.* at 17a.

ARGUMENT

The court of appeals correctly held that jurisdiction over petitioner's claims is precluded. Even if the district court had jurisdiction to issue a writ of mandamus, mandamus was not warranted in this case because petitioner failed to exhaust its administrative remedies. Furthermore, petitioner has now prevailed before the Board on its 1987 claim. Further review therefore is plainly unwarranted.

1. a. The district court lacked jurisdiction to consider petitioner's claims under 28 U.S.C. 1331. The Medicare statute expressly provides that "[n]o findings of fact or decision of the secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 1331 or 1346 of title 28 to recover on any claim arising under this subchapter." 42 U.S.C. 405(h) (incorporated into the Medicare Act by 42 U.S.C. 1395ii).

In *Heckler* v. *Ringer*, 466 U.S. 602 (1984), the Court held that 42 U.S.C. 405(h) bars the district court from asserting federal question jurisdiction over actions relating to claims under Part A of the Medicare Act. Under *Ringer*, a district court may assert jurisdiction over Part A reimbursement claims and legal issues that bear on those claims only *after* the plaintiff has exhausted the Medicare Act's administrative process. 466 U.S. at 627.

Petitioner cannot bypass the exhaustion requirement simply by framing a "constitutional" claim. Section 405(h) applies to "any 'action' seeking 'to recover on any [Social Security] claim'—irrespective of whether resort to judicial processes is necessitated by discretionary decisions of the Secretary or by his

non-discretionary application of allegedly unconstitutional statutory restrictions." *Weinberger* v. *Salfi*, 422 U.S. 749, 762 (1975). While Section 405(h) does not preclude constitutional claims, it "require[s] that they be brought under jurisdictional grants contained in the Act, and thus in conformity with the same standards which are applicable to nonconstitutional claims arising under the Act." *Ibid.*

Nor can petitioner bypass Section 405(h) by labelling its claims as "procedural" in nature. Both the district court (Pet. App. 13a-14a) and the court of appeals (*id.* at 5a) found that petitioner's attempt to characterize this action as procedural was suspect at best. In any event, this Court made clear in *Ringer* that exhaustion is required even if a party raises "procedural" objections or seeks declaratory relief to resolve those objections. 466 U.S. at 614-615. All such objections must "be channeled first into the administrative process which Congress has provided." *Id.* at 614.

b. Petitioner's contention (Pet. 20-23) that the Board's jurisdiction is limited, and that therefore petitioner will have no opportunity to obtain judicial review of its claims, is meritless. As this Court recognized in *Salfi*, Section 405(h) does not preclude judicial review of constitutional claims, but merely requires that petitioner first go through the administrative process. See 422 U.S. at 762. Nothing in the Medicare Act precludes petitioner from raising its constitutional claim after exhausting its administrative remedies. Indeed, the Medicare Act expressly provides that courts may consider legal issues not within the purview of the Board. See 42 U.S.C. 1395oo(f).

Petitioner's suggestion that exhaustion would serve no purpose in light of the Board's allegedly limited

jurisdiction is also incorrect. Exhaustion prevents "premature interference with agency processes," allows the agency to apply its expertise and correct its errors, and gives the agency a chance "to compile a record which is adequate for judicial review." *Salfi*, 422 U.S. at 765; see also *Ringer*, 466 U.S. at 619 n.12. In addition, exhaustion may obviate the need for judicial review, since the agency may award or deny the claimant relief on independent grounds. See *Salfi*, 422 U.S. at 762.

This case, like *Ringer* itself, "aptly demonstrates the wisdom of Congress' exhaustion scheme." *Ringer*, 466 U.S. at 619 n.12. The administrative proceedings resulted in the compilation of an administrative record that shed light on the various methods for determining whether executive compensation is reasonable. In addition, the administrative proceedings afforded the Board an opportunity to state its view as to how the statute and implementing regulations and directives should be applied. And in the end, petitioner *prevailed* in the administrative process on its claim for 1987. In accepting petitioner's claim, the Board expressly rejected the method proffered by Blue Cross for determining such compensation. See App., *infra*, 13a-14a.

c. Petitioner's suggestion (Pet. 20-22) that *Bowen* v. *Michigan Academy of Family Physicians*, 476 U.S. 667 (1986), establishes federal question jurisdiction for Medicare Part A claims is completely mistaken. In *Michigan Academy*, the Court held that a party challenging the Secretary's methods and procedures relating to Medicare *Part B* claims could seek judicial review under 28 U.S.C. 1331. See 476 U.S. at 678-681. At the time the Court decided *Michigan Academy*, the Medicare Act provided no mechanism for judicial review of Part B reimbursement claims. As a result, the Court declined to find that general

federal question jurisdiction was entirely precluded by 42 U.S.C. 405(h), because to do so would have precluded all judicial review of legal issues—including constitutional issues—that may affect Part B claims. See 476 U.S. at 680; see also *McNary* v. *Haitian Refugee Center, Inc.*, 111 S. Ct. 888, 899 (1991) ("Inherent in our analysis [in *Michigan Academy*] was the concern that absent such a construction of the [judicial] review provisions of the Medicare statute, there would be 'no judicial review at all of substantial statutory and constitutional challenges to the Secretary's administration of Part B of the Medicare program.'") (quoting *Michigan Academy*, 476 U.S. at 680). This case concerns *Part A* of the Medicare statute, not Part B. Because the Medicare Act provides a comprehensive scheme for judicial review of provider claims under Part A, see 42 U.S.C. 1395oo, the rationale of *Michigan Academy* does not apply to this case.[3]

2. Petitioner's contention that the district court had jurisdiction under the mandamus statute, 28 U.S.C. 1361, likewise merits no further review. This Court has declined to decide whether 42 U.S.C. 405(h) altogether precludes mandamus jurisdiction in cases in which mandamus jurisdiction would have been inappropriate in any event. See, *e.g.*, *Ringer*,

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[3] Four months after *Michigan Academy* was decided, Congress amended the Medicare Act to extend the administrative and judicial review procedures that are available to beneficiaries under Part A or Part B claims. See Act of Oct. 21, 1986, Pub.L.No.99-509, § 9341, 100 Stat. 2037. As amended, 42 U.S.C. 1395ff(b)(1) provides that a claimant may seek judicial review of "the amount of benefits under part A *or part B* of this subchapter." (emphasis supplied). As a result, the rationale of *Michigan Academy* no longer applies even under Part B. See *National Kidney Patients Ass'n* v. *Sullivan*, No. 91-5073 (D.C. Cir. Mar. 13, 1992), slip op. 11-14.

466 U.S. at 616; *Norton* v. *Mathews*, 427 U.S. 524, 528-533 (1976). This is such a case.

Mandamus is an extraordinary remedy that is available to a plaintiff "only if he has exhausted all other avenues of relief and only if the defendant owes him a clear nondiscretionary duty." *Ringer*, 466 U.S. at 616. As both courts below concluded, mandamus would be inappropriate in this case even if it were available, because petitioner failed to exhaust its administrative remedies.[4]

Petitioner incorrectly asserts (Pet. 17) that no alternative remedy is available because of the "restrictions" on administrative and judicial review under 42 U.S.C. 1395oo. The Board concluded that it had jurisdiction to consider petitioner's claim, see Pet. App. 11a, and in fact awarded petitioner complete relief for fiscal year 1987. But even if the Board had concluded that it lacked jurisdiction to decide petitioner's claims, petitioner could have obtained a judicial determination of those claims. Under 42 U.S.C. 1395oo, the court may review "a question of law or regulations relevant to the matters in controversy" that is beyond the jurisdiction of the Board. As a result, petitioner can obtain judicial review of its legal objections to the manner in which a fiscal intermediary resolved an executive compensation issue, simply by exercising its right to judicial review under 42 U.S.C. 1395oo after the Board renders its decision.

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[4] In addition, mandamus would be inappropriate because the Secretary does not owe the petitioner a clear, nondiscretionary duty to promulgate additional guidelines. The applicable regulation allows a fiscal intermediary to use "any appropriate means" to determine executive compensation. 42 C.F.R. 413.102(c)(2).

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted..

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MAY 1992

APPENDIX

PROVIDER REIMBURSEMENT REVIEW BOARD HEARING DECISION 91-D65

Case No. 90-0078

PROVIDER—TOTAL CARE, INC.
CHARLOTTE, NORTH CAROLINA

PROVIDER NO. 34-7091

VS.

INTERMEDIARY—BLUE CROSS AND BLUE SHIELD ASSOCIATION/BLUE CROSS AND BLUE SHIELD OF SOUTH CAROLINA

Date of Hearing—January 3 and 4, 1991

Cost Reporting Period Ended—December 31, 1987

ISSUES:

1. Whether the Intermediary's adjustment disallowing a portion of the owner's compensation is correct.

2. Whether the Intermediary's adjustment limiting the dues paid by the Provider to the costs of Homecare Alliance, an alleged related party, is correct. (On-the-Record)

SUMMARY OF FACTS:

The Provider is a home health agency (HHA) located in Charlotte, North Carolina. In the fiscal year ending December 31, 1987, it had home care visits totalling 69,098. The Intermediary furnished the Provider with a Notice of Program Reimbursement which questioned the above-claimed costs. The Provider filed a request for hearing to the Provider Reimbursement Review Board (Board) appealing the Intermediary's determination under the provisions of 42 C.F.R. §§ 405.1835-.1841 and has met the jurisdictional requirements of those regulations.

Issue 1—Owner's Compensation

The chief operating officer, the owner of the Provider, received $86,322 of compensation in 1987 consisting of $87,583 of salary, $2061 of shared management services, and $800 of director's fees. The Intermediary evaluated that compensation using a guideline known as the "Tennessee Point System." The "Tennessee Point System" is based on HHA services performed, and uses a combination point/visit method developed by Blue Cross and Blue Shield of Tennessee. The Health Care Financing Administration's (HCFA's) Atlanta Regional Office performed a sal-

ary survey of 94 HHAs in 1975 that was used to develop the Tennessee Point System. The 1975 data base salary ranges were updated for inflation using factors developed by HCFA. Applying the survey results to the Provider's owner compensation resulted in $57,308 in allowable compensation. That limitation reduced Medicare reimbursement by approximately $25,000.

Provider's Contentions:

The Provider contends that the Intermediary's adjustments to the Provider's claimed owner's compensation in 1987 are unreasonable and unlawful. The adjustments were not made by comparing compensation paid for comparable services and responsibilities in comparable institutions. The Intermediary completely ignored the most comparable compensation and institution available—the Provider. In 1984 and 1985, the Blue Cross and Blue Shield Association (BCBSA) reversed Blue Cross and Blue Shield of North Carolina's adjustment to owner's compensation and allowed owner's compensation in full. In 1986, the Intermediary made no adjustment to the Provider's claimed compensation. Thus, it allowed full compensation of $67,649, $69,398 and $70,632 for 1984-1986, respectively. The Intermediary ignores the fact that it and other intermediaries allowed similar or higher salaries for other HHA owners at comparable institutions. The Provider's visits increased by 9% from 1983 to 1987, while its revenue increased by $331,273 or 12%. Despite this, the Intermediary's adjustment to the 1987 salary placed it $10,341 less than what BCBSA allowed in 1984. Taking the 1984 salary allowed by BCBSA and multiplying it by the Consumer Price Index yields a reasonable salary of

$89,386 for 1987. Increasing the 1984 BCBSA allowed salary by the nationally-recognized Hay Management Consultants (Hay) index of 6.6% (annual salary increase) results in a reasonable salary level of at least $81,947.

The Intermediary has not compared the owner's compensation with other comparable institutions using the "other appropriate means" regulatory requirement in 42 C.F.R. § 413.102(c)(2). Because HCFA has not approved the use of "other appropriate means," BCBSA and its subcontractor plans have failed to explain where they obtained the authority to use the "Tennessee Point System" or any other method to adjust the Provider's cost report. The Intermediary has failed to produce any data to support the "Tennessee Point System." Moreover, the Intermediary's reliance on the "Dunham II" study, another point/compensation evaluation system, to arrive at an alternative compensation for the owner's compensation constitutes an unlawful reopening of the cost report. Its use of that study, which was developed in 1990, to support its 1989 adjustment of the 1987 cost report constitutes unlawful retroactive rulemaking. Finally, the Intermediary failed in its responsibility as a regional home health intermediary to develop uniform cost and performance criteria.

The Provider's claimed owner's compensation in 1987 was reasonable and not substantially out-of-line. The amount of compensation paid in 1987 is reasonable as supported by another study, the "Dunham I" study. In 1984, Dr. Dunham completed a study of many of the positions of employment at Total Care, including the owner's position, president/chief executive officer. This study, "Dunham I", was based on a

methodology involving the use of the Professional and Managerial Position Questionnaire (PMPQ) to identify comparable responsibility levels in HHA jobs and hospital jobs so that compensation levels for HHA jobs could be developed based on the actual salaries paid for comparable hospital jobs. The Provider's owner completed the PMPQ on her own which resulted in a total of 2525 PMPQ points in 1984. Dr. Dunham extrapolated that result to correspond with a pay range of $46,082 to $76,804. To determine the appropriate 1987 pay range, the 1984 range was trended forward by 6.6% per year, the inflation factor recommended by the Wyatt Company which developed the underlying hospital data used in "Dunham I". T-1, pp. 90-91. Utilizing that inflation factor yields a recommended pay range of $54,884 to $91,475 for 1987. Given the owner's actual salary in 1987 was $86,322, Dr. Dunham concluded that her 1987 salary was reasonable. T-1, p.96.

The amount of compensation paid in 1987 is reasonable as supported by the "Dunham II" study. The "Dunham II" methodology was based on essentially the same procedures as "Dunham I", but used 1990 hospital salary data. It differed from the earlier study, however, in that it involved the development of a regression equation to relate PMPQ points to hospital salaries. The Provider participated in the "Dunham II" study, and its owner received a score of 2830 points on her PMPQ. Based on this score, Dr. Dunham recommended a 1990 salary range of $68,054 to $105,082. Using Dr. Dunham's suggested deflation factor of .781, the appropriate salary pay range for 1987 was $53,150 to $82,069. Despite Dr. Dunham's expert opinion on the proper use of the pay ranges that he developed, the Intermediary focused solely on

the midpoint of the 1990 range ($86,068), and trended it backward to impose a 1987 midpoint salary cap of $66,438.

The amount of compensation paid in 1987 is also reasonable as supported by Hay. Hay provides compensation consulting to BCBSA and approximately twenty-eight Blue Cross plans in the United States. T-1, p.212, and T-2, p.42. In 1985, the Provider commissioned Hay to review its pay structure. Based on the Hay Chart Guide Profile Method of Job Evaluation, which focuses on the know-how, problem-solving and accountability dimensions of a particular job and based upon a database of thousands of companies, Hay originally recommended a 1985 salary range for the owner between $50,000 and $75,900. T-1, p.236. On the Provider's 1985 cost report, it claimed $69,398 of owner's compensation which the Intermediary allowed. For 1987, the Hay salary range was $69,248 to $103,480. On the cost report, the Provider claimed $86,322 in compensation, well within the Hay range.

The amount of compensation paid in 1987 is reasonable when compared with salaries paid by other home health agencies in North Carolina. The regulations require the Intermediary to reimburse providers for a reasonable allowance of compensation provided the amount is not substantially out of line with other, similarly situated providers. Given that the owner's salary at the Provider was within range or less than the salaries claimed and allowed by owners of comparable HHAs in 1987, her salary was both reasonable and not substantially out-of-line.

During the hearing, the owner testified that she had personal knowledge that other HHA administrators earned more than she did. T-2, p.146. The independ-

ent accountant for the Provider confirmed in his testimony that Medicare has allowed significantly more for other agencies. T-2, p.222.

Intermediary's Contentions:

The Intermediary contends that 42 C.F.R. § 413.102 (c)(2) allows it to determine reasonable compensation by "other appropriate means". This method is supported by Provider Reimbursement Manual (PRM) § 902.3 which defines reasonable compensation as the fair market value of services rendered by an owner in connection with patient care. Fair market value is determined by supply and demand factors of the open market. There is no open market for positions like the Provider's owner/administrator. Therefore, "other appropriate means" of determining owner's compensation must be made. Since there are no data for comparable salaries set by open market forces, the Intermediary has not developed salary surveys of HHAs.

The "Dunham II" study used by the Intermediary as an alternative to the "Tennessee Point System" study is an adequate "other appropriate means" as stated in 42 C.F.R. § 413.102(c). In fact, the "Dunham II" study followed a methodology that the Provider appeared to sponsor. The Provider submitted the study within two weeks of the hearing. Since it thought that the study had sufficient probative value to enter it into the record, the Provider should not object to the Intermediary's modified adjustment which was based on that study. The study which compares HHA positions with hospital jobs of similar responsibility levels is the best tool available for intermediaries to use to measure the reasonableness of HHA compensa-

tion. Also, any errors in the study's premises are in the favor of HHA owners.

The study is a good basis for comparison because there are general open market conditions for hospital employees. Also, there are longstanding independent management consultant studies available to objectively measure hospital administrative positions. The Provider's witness indicated that there was no similar general study for HHA positions. T-1, pp.111-112. Hay, the party that helped establish the Provider's owner's compensation, used its own hospital database and some informational data from the National Association of Home Care. T-2, p.10. Hay did not have any home health agency database to work with. T-1, p.235. The fact that both Dunham and Hay had access to information on hospital salaries and no comparable information on HHA salaries, supports the Intermediary's position that there really was no open market for establishing HHA administrators' compensation levels. Moreover, the Board has considered methods such as the Dunham studies and comparisons to small hospitals as "other appropriate means" for determining the reasonableness of HHA owners' compensation.

The Intermediary does not agree with the Provider that its allowance of the owner's compensation in 1986 precludes it from making an adjustment on the 1987 compensation using either the "Tennessee Point System Method" or the "Dunham II" study. The original adjustment on 1987's compensation was reasonable. Using the 1989 Modern Healthcare Survey for hospitals with revenue of $7 to $20 million, and deflating its results to 1987 levels, results in a compensation of $60,300. That is comparable to the $58,308 established by the "Tennessee Point System."

The 1990 "Dunham II" study, deflated to 1987 dollars, produced a recommended salary of $66,438. This is a reasonable, alternative compensation.

The Hay study recommendation that the Provider used to establish its owner's compensation level is less reliable than the "Dunham II" study. The Hay study results in a midpoint compensation of $73,400 which is substantially above the "Dunham I" study and "Dunham II" study midpoints. The Hay analysis produced 1486 PMPQ points. Further, the actual chart used to develop the Provider's owner points is not in the record. T-2, p.8. The Hay study ignores job titles and has a premise that "points are points." Its universe of hospital positions to develop salaries was taken from a database of 21 hospitals under 500 beds. However, these hospitals were all Hay clients which tend to be larger hospitals. Therefore, the 21 hospitals in the database would probably be closer to 500 beds than 100 beds. T-2, p.39.

In reviewing the Dunham studies, the Board has expressed reservations about the comparability of HHAs to hospitals. However, Dr. Dunham at least did his analysis using widely published data from hospitals of all size ranges including smaller hospitals with revenue bases larger (but closer) to the Provider's than the hospitals Hay used.

Issue No. 2—Dues Paid to Alliance

In April 1987, five HHAs collectively formed Home Care Alliance of Southwest, Inc. (Alliance), a proprietary corporation, to provide its owners shared management, bulk purchasing, and group insurance coverage. Two blocks of stock were issued to the founding agencies. One block was issued to the

HHAs which had voting power. The other block was sold to the chief executive officer of each facility. At the inception of Alliance, the Provider had a 20% ownership. In November 1987, another provider joined the group. As a result, the Provider's percentage of ownership dropped from 20% to 16%. The Provider's owner also had a 5% ownership in Alliance's preferred stock.

The Provider claimed $3,500 of dues paid to Alliance as an allowable cost. The Intermediary considered the Provider and Alliance as related parties under 42 C.F.R. § 413.17, and allowed $2,146 of the dues. Its disallowance of $1,354 was the Provider's share of Alliance's total profit of $7,902 in 1987.

Provider's Contentions:

The Provider contends that this adjustment is erroneous. First, the stated basis for the adjustment is the related organization regulation although the Intermediary actually allocated profits to members of the Alliance to determine the amount of the adjustment. Second, the Intermediary has not shown that the Provider and Alliance are related by either common ownership or control as required in the related organization provisions of 42 C.F.R. § 413.17. Common Ownership means "significant ownership or equity interest" in the provider and in the supplying organization. Informally, HCFA and the Board have indicated that significant ownership means at least 20% ownership in the supplying organization. The Provider owned 20% of the common stock of the Alliance between April 10, 1987, and November 1987. However, the Provider's share of common stock ownership was 16.67% during November and December. The Provider's owner had but 5% of preferred stock while the remaining 95% was owned by people out-

side of the Provider. Since the Provider did not own over 20% of the Alliance in 1987, there is no common ownership under the related organization regulation.

Control means "the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization." 42 C.F.R. § 413.17(b)(3). The Provider's relationship with Alliance fails to satisfy the control rules and, therefore, the two organizations are not related. The Provider lacked the ability to control the actions or policies of Alliance since it controlled only between 16.67% and 20% of the common stock (the voting power) of the Alliance. However, the Provider's owner was not a director of Alliance in 1987. Moreover, the other shareholders of Alliance were the Provider's competitors, and the competitors owned 95% of the preferred stock. By definition, these facts would not allow the Provider or its owner the power to exercise significant influence or control over Alliance.

Intermediary's Contentions:

The Intermediary contends that the Provider and Alliance are related by common ownership and control in accord with 42 C.F.R. § 413.17. The element of common ownership is present in both the Provider and Alliance. Ms. Peggy Davis owns 100% of the stock of the Provider. The Provider's ownership in Alliance ranged from 16.67% to 20%. In addition, Ms. Davis personally owns stock in Alliance.

The element of control is present in both the Provider and Alliance. Ms. Davis is President and Chief Executive Officer of the Provider. The Provider stated that Ms. Davis was not an officer of Alliance and she

was not in a position to exercise control over it. This statement is in direct contradiction with information contained in the minutes of the Board of Directors of Alliance. According to those minutes, Ms. Davis was elected Vice-Chairman and Secretary of Alliance. In fact, she was the only person to hold two offices.

The Provider maintains that because internal HCFA pronouncements have indicated that stock ownership of less than 20% is not a "substantial ownership" as defined by PRM §§ 1000 and 1004, the Provider and Alliance are not related organizations. First, the Provider's ownership in Alliance was not less than 20% until the last two months of the year. Second, the Intermediary does not have copies of any HCFA pronouncement stating that stock ownership of less than 20% is not a "substantial ownership." However, the minutes from the Regional Home Health Intermediaries (RHHI) which was held in October 1989, indicated that a 10% of ownership is used by most RHHIs as a benchmark of "substantial" ownership.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

Law—Title XVIII, Social Security Act:

§ 1861(v)(1)(A) —Reasonable Cost

Regulations—42 C.F.R. § 405, Subpart D:

a) § 413.102(c) —Compensation of Owners

b) § 413.17(b)(1) —Related to the Provider

c) § 413.17(b)(2) —Common Ownership

d) § 413.17(b)(3) —Control

Program Instructions—Provider Reimbursement Manual (HIM 15-1):

a) § 902.3	—Reasonableness
b) § 1000	—Principle
c) § 1004	—Determination of Common Ownership Or Control

FINDINGS AND CONCLUSION:

The Board, after considering the facts, contentions of the parties, evidence submitted, and post-hearing briefs finds and concludes as follows:

Issue No. 1—Owner's Compensation

The Board finds that the $86,322 compensation paid by the Provider to its owner/administrator is reasonable based on Hay's January 1985 study of the Provider's administrative positions. The witness from Hay testified that the American Health Care Management Survey showed a compensation range of $50,591-$75,887, with a midpoint of $63,239. Trending those dollars forward to 1987, the year in dispute, results in a range of approximately $80,000 to $120,000, with a midpoint of approximately $88,000. The owner's compensation at the Provider falls within that range and is, therefore, reasonable.

The Board notes that the Dunham studies are based on the job responsibilities in HHAs and hospitals. It assumes that a job in an HHA should be paid at the same level as a job with similar responsibilities in a hospital. However, the author of the study testified that there is no statistical proof of the validity of that assumption. T-1, pp.190-191. The witness said

that his methodology assumed the validity of the principle of comparable worth. T-1, pp.191-192. More specifically, the PMPQ was predicated on the principle of comparable worth. T-1, p.192. Although there is no evidence of it in the record, the witness testified that the labor pools for hospitals and HHAs are comparable. Most significantly, the witness testified that *market factors were not included in his analysis.* T-1, p.194. Therefore, his methodology assumes that it is equally easy/difficult to recruit employees in hospitals and HHAs!

Regulation 42 C.F.R. § 413.102(b)(2) states that, "[r]easonableness requires that the compensation allowance—(i) Be such an amount as would ordinarily be paid for comparable services by *comparable* institutions" (emphasis added). The methodology employed by Dr. Dunham does not take into account salary amounts paid by comparable institutions. By referring to comparable services in comparable institutions, the regulation must include the market forces that determine salaries. In ignoring market factors, Dr. Dunham's methodology does not comply with the requirements of the regulation.

Also, the principle of comparable worth, on which the validity of the PMPQ is predicated, does not include variations arising from demand and supply in the marketplace. In relying on the validity of the principle of comparable worth, the study by Dr. Dunham again does not comply with the requirements of the regulation.

Issue No. 2—Dues Paid to Alliance

The dues paid by the Provider to Alliance are payments made between related parties as defined in 42 C.F.R. § 413.17. The Provider is related to the group purchasing company through ownership. Its 16-⅔% to 20% ownership in this company during the year in dispute meets the regulatory definition of common ownership, 42 C.F.R. § 413.17(b)(2). Moreover, the Provider exercises control over the group purchasing company as defined in 42 C.F.R. § 413.17(b)(3). The Provider and its owner had the power to directly and significantly influence the actions and policies of the organization. The owner's position of Vice-Chairperson and Secretary of the Alliance clearly demonstrates that she had the power to significantly influence its policies. Allowable costs are, therefore, limited to only the costs incurred by Alliance.

DECISION:

Issue No. 1—Owner's Compensation

The $86,322 of compensation paid to the owner of the Provider is reasonable. The Intermediary's adjustment is reversed.

Issue No. 2—Dues Paid to Alliance

Alliance and the Provider are related parties. Allowable costs are limited to the costs incurred by the group purchasing company. The Intermediary's adjustment is affirmed.

Board Members Participating:

Keith E. Braganza
Sally A. Kirkpatrick
Joseph F. Sloan

FOR THE BOARD:

Aug. 22, 1991

/s/ Jack Martin
JACK MARTIN
Chairman

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Office of Attorney Advisor
6325 Security Boulevard
Baltimore, Maryland 21207

Oct. 10, 1991

Charles F. MacKelvie, Esquire
Hinshaw, Culbertson, Moelmann, Hoban and Fuller
222 North LaSalle Street
Suite 300
Chicago, Illinois 60601-1081

Dear Mr. MacKelvie:

Re: *Total Care, Inc.*, PRRB Case No. 91-D65 (08/22/91) (FYE 12/31/87)

This is to advise that the Administrator of the Health Care Financing Administration has declined to review the decision entered by the Provider Reimbursement Review Board in the captioned case.

If the Provider wishes to obtain judicial review of the matter, civil action must be initiated within 60 days of the date the Board's decision was received in accordance with 42 CFR 405.1877.

Sincerely yours,

/s/ Marion T. Silva
MARION T. SILVA
Attorney Advisor

Enclosure

cc: Bernard M. Talbert, Esquire, Intermediary's Headquarters

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